



# Health Net® Enrollment/Change Request

**Employer Group Information** – To be completed by employer.

Group Name \_\_\_\_\_  
 Group Number \_\_\_\_\_  
 Class Code \_\_\_\_\_

**A. TYPE OF ACTIVITY** – To be completed by employer. Refer to instructions on back before completing this form. Print clearly.

<b>1. Enrollment</b> <input type="checkbox"/> New Enrollee Effective Date _____ Date of Hire _____	<b>2. Change</b> – Check all that apply <input type="checkbox"/> Add Spouse _____ <input type="checkbox"/> Add Domestic Partner _____ <input type="checkbox"/> Add Dependent Child _____ <input type="checkbox"/> Name Change _____ <input type="checkbox"/> Change Plan _____ <input type="checkbox"/> Other _____	<b>3. Remove or Terminate</b> – Check all that apply <input type="checkbox"/> Remove Spouse* _____ <input type="checkbox"/> Remove Domestic Partner _____ <input type="checkbox"/> Remove Dependent Child* _____ <input type="checkbox"/> Employee Withdrawal/Termination _____ Note: Employee must be enrolled for spouse/dependent to have coverage. *Please complete <i>Add/Change/Remove</i> and <i>Name</i> columns in Section D.	<b>4. Continuation of Coverage</b> , i.e. COBRA, State, total disability. Not all options are available or applicable. Contact [Employer] for available options. Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos <input type="checkbox"/> total disability* Date of Loss of Coverage: _____ Date of Qualifying Event: _____ * Attach proof of total disability
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**B. EMPLOYEE INFORMATION** – Complete Sections B-H

Last Name, First Name, M.I. \_\_\_\_\_ Social Security Number \_\_\_\_\_ Home Telephone \_\_\_\_\_  
 Home address \_\_\_\_\_ Apt. No \_\_\_\_\_ City, State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Work Telephone \_\_\_\_\_  
 Work address \_\_\_\_\_ City, State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Date of Employment: \_\_\_\_/\_\_\_\_/\_\_\_\_ Hours worked per week: \_\_\_\_\_

**C. PLAN OPTION** – Your selection must be offered by your Employer

**Check one:**  
 Charter HMO  Passport HMO  Charter POS  Passport POS  PPO  Other: \_\_\_\_\_  
**Type of Contract:** (Select one):  
 Single  Husband/Wife  Domestic Partner  Adult & Child(ren)  Family

**D. INDIVIDUALS COVERED** – List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time post-secondary student. Attach proof of disability

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birth date MM DD YYYY	Social Security Number	Other Health Coverage	Other Rx Drug Coverage	Primary Office ID Number	Previous Coverage Check if yes
Employee			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Domestic Partner			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Spouse			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Child			<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

**E. PRE-EXISTING CONDITIONS STATEMENT**

NOTE: This information may ONLY be used to determine if a condition is a pre-existing condition.

You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes  No 1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

- |   |   |
|---|---|
| <input type="checkbox"/> a. Alcoholism or Drug Abuse              | <input type="checkbox"/> g. Gastro or Intestinal Disorder             |
| <input type="checkbox"/> b. Arthritis                             | <input type="checkbox"/> h. Heart Disorder or Condition or Chest Pain |
| <input type="checkbox"/> c. Blood Disorder                        | <input type="checkbox"/> i. High Blood Pressure                       |
| <input type="checkbox"/> d. Back or Neck Disorder, Injury or Pain | <input type="checkbox"/> j. Kidney or Liver Disorder                  |
| <input type="checkbox"/> e. Cancer or Tumors                      | <input type="checkbox"/> k. Lung or Respiratory Disorder              |
| <input type="checkbox"/> f. Diabetes                              | <input type="checkbox"/> l. Mental or Nervous Disorder                |
|   | <input type="checkbox"/> m. Paralysis, Stroke or Epilepsy             |

2. During the past 6 months, have you or any dependent to be covered:  
Yes No

- a. been examined or treated by a physician or other health care provider for any condition, illness, or injury, other than as stated above?
- b. been advised to have treatment or surgery or testing that has not been done?
- c. been admitted to a hospital or other health care facility as an inpatient?
- d. taken prescribed medication?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

**F. OTHER/PREVIOUS INSURANCE**

Is your spouse employed?  Yes  No If "yes" give name and add your spouse's employer \_\_\_\_\_  
If "yes" to Other Health Coverage (Section D), give name(s) and policy number(s) of insurance carrier, HMO, or other source.

If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID # \_\_\_\_\_  
If "yes" to Other Rx Drug Coverage (Section D), give name and policy number of insurance carrier, HMO, or other source.

If "yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number, and submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.

**G. DEPENDENT INFORMATION**

Does any dependent listed in Section D live at a different address than the Employee.  Yes  No If "Yes" who and at what address? Explain the circumstances. \_\_\_\_\_

If any dependent's last name differs from yours, explain the circumstances. \_\_\_\_\_

**H. EMPLOYEE SIGNATURE**

*If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Contact Center representative at 800- 441- 5741 before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

Employee Signature –Required X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_.

**I. EMPLOYER VERIFICATION – To be completed by Employer**

Employer Signature –Required X \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_.

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Health Net prior to visiting a specialist or admission to a hospital.



## INSTRUCTIONS

### EMPLOYER

- Complete the Employer Group information on the upper right hand corner of the form.
- Section A –  
Type of Activity: Check boxes indicating reason(s) for submitting application.
- Complete Section I – Employer Verification of the form.
- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request in order for it to be processed.

### EMPLOYEE – COMPLETE SECTIONS B-H

#### Section B – Employee Information:

- Complete all information in order for your application to be processed.

#### Section C –Plan Option:

- Check one Plan Option box, indicate Plan Option Name (where applicable) and check one Copay and/or Individual Deductible Amount (if applicable).
- Select only an option offered by your employer.

#### Section D–Individuals Covered:

- Add/Change/Remove –Use “A”, “C”, or “R” to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability
- If you or your dependent(s) have other Health or Rx drug coverage, check off the “ Yes” box(es) and complete Section F –Other/Previous Insurance.
- From the appropriate provider directory, locate the office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- If you are a current patient, please check the “ Current Patient” box.

#### Section E – Pre-Existing Conditions Statement:

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2–5 employees and by late entrants.

#### Section F Other / Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

### Section G – Dependent Information

- Complete this section for all new enrollments or coverage changes

### Section H –Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

### Section I – Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

## CONDITIONS OF ENROLLMENT

### Applicant Acknowledgement and Agreements

On behalf of myself and the dependents listed on the reverse side I agree to or with the following:

- a) I authorize the sources stated below to give to Health Net , or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.  
b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Health Net has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.  
c) I know that I have a right to receive a copy of the authorization if I request one.  
d) I agree that a photocopy of this authorization is as valid as the original.
  - I acknowledge by enrolling in a Health Net plan or group policy coverage is provided by Health Net in accordance with the contract.
  - Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Health Net.
  - Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.
- ### Misrepresentation
- Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.